# EXHIBIT S

Jul. 12. 2017 2:50PM PS2100 HMC HR No. 4955 P. 1

CONFIDENTIAL

HARBORVIEW MEDICAL CENTER

325 9th Ave., Box 359715
Seattle, WA 98104

# Facsimile Cover Sheet

| | | | |
|---|---|---|---|
| To: | M. Reid Stell LMHC | From: | Kim Francis |
| Reciever's Organization: | Reid Stell Counseling | Phone: | 206-744-9229 |
| RE: | Marthilde Brzycki | Fax: | 206-744-9955 |
| Fax: | 206-858-9206 | Email: | kimfran@uw.edu |
| Date: | July 12, 2017 | Pages: | 4 including cover |

Mr. Stell,

We received the disabiliyt accommodation paperwor for your patient Mattie Brzycki (our employee) indicating she has restrictions including ***"patient has the ability to meet psychological demands of the job as described by the patient –No"*** and recomending a continuous leave of absence beginning with her scheduled shift on Monday 7/17/17. Ms. Brzycki is scheduled to work on Friday 7/14/17 and has expressed a desire to wrap up patient care items on this date prior to the extended medical leave. However, based on the restriction above we would like you to clarify that she is released to perfom the following duties.

Ms. Brzycki saw 6 patients on 7/11/17 so on Friday she will need to complete all documentation on those 6 patients and close the charts. This would include utilizing her template to complete H&P's, plans of care, education, med lists and any other care that was discussed or performed at the time of the visit. In addition to this she may need to email Dr Tirschwell (her colleague) any outstanding medical concerns for those patients that need to be followed up on. She will need to copy the Program Manager on those emails regarding patients so she can ensure the patients get the follow up care they need. Also any outstanding work will need to be communicated to the Program Manager (email is fine) so the department can ensure completion.

☒ Ms. Brzycki can perform this work without restrictions. M. Stell, LMHC 7/12/17

If Ms. Brzycki cannot perform this work, but could with accommodatons, please describe the accommodatons recommended.

Once this information is complete it can be faxed back to me at the number above, and please feel free to call me if you have any additional questions. Thank you.

Thank you.

Sincerely,

Kim Francis
HR Leave Specialist

EXHIBIT 3
STELL
11/7/2019
Buell Realtime Reporting
206-287-9066



Received Time Mar. 29. 2019 2:03PM No. 3312

UNIVERSITY OF WASHINGTON | Human Resources | Disability Services Office

# HEALTH CARE PROVIDER STATEMENT

Disability Accommodation

**EMPLOYEE COMPLETES THIS SECTION**

| Name (Last) | (First) | (MI) | Department |
|---|---|---|---|
| BRZYCKI | MARTHILDE | — | STROKE Center |
| **Employee's Job Title** | **Work Email** | | **Work Phone** |
| NURSE PRACTITIONER | MJeanty@UW.edu | | 206-744-2632 |
| **Work Schedule (days/hours)** | | | |
| ~~M 7:30-11:30~~, M, T, W, F 20 HRS (New) MT 7:30-12:30, T 12:30-5:30, W 7:30-12:30, Fri 10:30-4:30 | | | |
| **Name of Health Care Provider** | **Employee Patient No./Date of Birth** | | **Health Care Provider's Phone** |
| REID STELL | | | 206-457-3038 |

I hereby authorize the above-named health care provider to complete this form and disclose to the University of Washington and its authorized representatives the following information related to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports and correspondence.

I understand that it may be necessary for the University representatives to share this information for purposes related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

**I hereby authorize my health care provider to discuss directly with University representatives any medical/mental health information relevant to my accommodation request.**

**By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE TO EMPLOYEE): If you do not provide authorization for your health care provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.**

Employee's Signature Marthilde Brzycki Date 7/12/2017

**(To Employee: DO NOT RETURN THIS FORM TO YOUR DEPARTMENT SUPERVISOR)**

Return all completed employee and health care provider portions of this form to the designated UW Human Resources office or the Disability Services Office.

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**DISABILITY SERVICES OFFICE**
206-685-7264 (fax) 206-543-8450 (v)
1100 NE Campus Parkway (Condon Hall)
Box 354560
Seattle, WA 98105-6261

If form is faxed, please be sure to send a hard copy by mail, too.

(To HR: Check all parts to be completed by the Health Care Provider) HR Consultant:

**HEALTH CARE PROVIDER COMPLETES THIS SECTION**

**Your patient is requesting an accommodation regarding her/his employment. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this employee. Please be thorough in your evaluation as you complete the attached sections as it will help us assist your patient. Your timely completion of this form is essential to our ability to respond to your patient's accommodation request.**

**Please complete Parts I, II, III and any additional sections checked below. If you fax the completed form, please send the original hard copy by mail to the address designated at the bottom of page one.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

| | |
|---|---|
| ☒ I. Evaluation Summary (Page 2) | ☒ V. Cognitive/Psychological Capacities Evaluation (Page 4) |
| ☒ II. Health Care Provider Signature (Page 2) | ☒ VI. Other Restrictions & Effects of Medication (Page 4) |
| ☒ III. Ability to Work Summary (Page 2) | ☒ VII. Disability Parking/Transportation Evaluation (Page 5) |
| ☒ IV. Physical Capacities Evaluation (Page 3) | |

**I. EVALUATION SUMMARY**

| Pertinent Diagnosis(es) | Describe Related Functional Limitation(s): | Temp. Perm? | Onset; Duration of treatment for this condition? |
|---|---|---|---|
| F4322 ADJ. DIS. W/ANX | ALL JOB FUNCTIONS PRECLUDED | Temp. | OCT. 2016 - 9 MO. |
| F4310 PTSD | RECEIVED | | |
| | JUL 13 2017 | | |
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Is this condition the result of an on-the-job illness or injury? ☒ Yes ☐ No

**II. SIGNATURE OF HEALTH CARE PROVIDER**

| Health Care Provider Name (please print or type) | Provider's Specialty: Please indicate any board certifications | | |
|---|---|---|---|
| M. Reid Stell, LMHC NPI 1881979946 | PSYCHOTHERAPY: ANX, DEP, TRAUMA | | |
| Health Care Provider's Address (Street) | City | State | ZIP |
| 14535 BEL-RED RD., SUITE 202 | BELLEVUE | WA | 98007 |
| M. Stell — Health Care Provider Signature | 7-12-17 Date | Phone No. 206-457-3038 | Fax No. 206 858 9206 |

**III. ABILITY TO WORK SUMMARY**

Please check appropriate box:

My assessment is based on *(select one)*: ☐ Written Job Analysis; ☐ Written Job Description; ☒ Job as described by the employee

A. Choose only one of the following:

- ☐ The employee/patient CAN now perform all the duties of the CURRENT job: (IF CHECKED, STOP HERE, SIGN AND RETURN FORM)
- ☐ The employee/patient CAN now perform all the duties of the CURRENT job with proposed modifications. (Complete Section B)
- ☐ The employee/patient CAN return to this job after a medically necessary leave. (Complete Section C.), or
- ☐ The employee/patient CANNOT, and will not be able to perform the essential duties of the current position even after a leave of 6 months, and CANNOT work at least 50% time in another job: (IF CHECKED, STOP HERE, SIGN AND RETURN THE FORM)
- ☐ The employee/patient will not be able to perform the essential duties of the current position within the next 6 months, but CAN now work at least 50% time in another job. State maximum percent time ~~[illegible]~~ 50% (Go to Sect. IV, page 3 and Sect. V, page 4 (as appropriate)).

B. I recommend a ☐ Temporary or ☒ Permanent modification of the employee's job that I have determined to be medically necessary (e.g. work schedule, lifting, graduated return to work, etc.)
Duration of proposed modification: from: (mm/dd/yy) 07/12/17 to: (mm/dd/yy) →

C. I recommend a medical leave of absence from: (mm/dd/yy) 07/15/17 to: (mm/dd/yy) UNKNOWN
Employee/patient will be able to return to work on: (mm/dd/yy) UNKNOWN

## V. COGNITIVE/PSYCHOLOGICAL CAPACITIES EVALUATION

Patient Name Last: Brzycki First: Mathilde MI: A

Statement of psychological/cognitive diagnosis(es). *(Include the ~~DSM-IVR~~ diagnosis):* ICD10

CX PRESENTS W/ ACUTE ANX. + PANIC SXS: F4322 ADJ. DIS. W/ ANX.

How often is patient receiving treatment from you and/or another health care provider for this condition?

2X/MO.

**Health Care Provider: Please identify functional limitations of diagnosis(es):**

| | |
|---|---|
| Patient has the ability to meet the cognitive demands of the job as described in the cognitive job analysis or job description. *(select one)* ☐ Cognitive Job Analysis ☐ Job Description ☒ Job as described by employee | ☒ Yes ☐ No |
| Patient has the ability to meet the psychological demands of the job as described by the cognitive job analysis or job description. *(select one)* ☐ Cognitive Job Analysis ☐ Job Description ☒ Job as described by employee | ☐ Yes ☒ No |
| Patient has the ability to multitask without loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources. | ☐ Yes ☒ No |
| Patient has ability to work and sustain attention with distractions and/or interruptions. | ☐ Yes ☒ No |
| Patient is able to interact appropriately with a variety of individuals including customers/clients. | ☒ Yes ☐ No |
| Patient is able to deal with people under adverse circumstances. | ☐ Yes ☒ No |
| Patient has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships. | ☒ Yes ☐ No |
| Patient is able to maintain regular attendance and be punctual. | ☒ Yes ☐ No |
| Patient is able to understand, remember and follow verbal and written instructions: Simple instructions / Detailed instructions | ☒ Yes ☐ No / ☒ Yes ☐ No |
| Patient is able to complete assigned tasks with minimal or no supervision. | ☒ Yes ☐ No |
| Patient is able to exercise independent judgment and make decisions. | ☒ Yes ☐ No |
| Patient is able to perform under stress and/or in emergencies. | ☒ Yes ☐ No |
| Patient is able to perform in situations requiring speed, deadlines, or productivity quotas. | ☒ Yes ☐ No |

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*Clarify or add any additional information here:* CX WOULD BE ABLE TO PERFORM PATIENT CARE AND REPORTING DUTIES AT THE HIGHEST LEVEL BUT FOR REPORTED DISCRIMINATION HARASSMENT AND HUMILIATING TREATMENT BY MANAGERS MAINTAINING A HOSTILE WORK ENVIRONMENT.

## VI. OTHER RESTRICTIONS & EFFECTS OF MEDICATION

If there are other restrictions you have not described above, please describe here:

CX WOULD BE ABLE TO WORK AT ANOTHER U.W. FACILITY.

Anticipated duration of these restrictions?

RECOMMEND IMMEDIATE TRANSFER.

Are these restrictions medically necessary? ☒ Yes ☐ No

Is patient currently prescribed medication that would impair ability to operate machinery, be punctual, or maintain regular attendance?

☐ Yes ☒ No

If Yes, please explain, including the expected duration that employee will be prescribed this (or a similar) medication: